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| Lived experience workforce positions report |
| Victorian mental health and alcohol and other drug services 2019**–**20 |
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| Lived experience workforce positions reportVictorian mental health and alcohol and other drug services 2019–20 |
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# Acknowledgements

## Acknowledgement of country

We acknowledge the traditional owners and protectors of the earth, skies and waters today.

We acknowledge their ancestors who have cared for this land and all the creatures that live upon it for thousands of generations.

We pay our respect to the future protectors who are continuing on this path.

## Recognition of lived experience

We recognise all people with a lived experience of trauma, neurodiversity, mental ill health and substance use or addiction, and their families, carers and supporters. This recognition extends to the clinical and non-clinical workforces that support people with lived experience.

# Introduction

In 2019–20 a census survey was sent to Victoria’s state-funded mental health services and alcohol and other drug (AOD) services to identify paid lived experience positions. Workforce data related to mental health lived experience positions was collected for the first time in 2017, which now allows for a comparative analysis of the two data points. The scope of the 2019–20 survey was also expanded to include the AOD sector and establishes a baseline for measuring change to AOD peer workforce positions over time.

This census data expands on the information collected in the Mental Health Establishments survey, which provides information about consumer and carer worker full-time equivalent (FTE) positions within Victorian public mental health services.

To be in scope for census reporting, positions must be:

* paid roles in Victorian public mental health services that include lived experience of mental health issues or of supporting someone with mental health issues as an essential part of the selection criteria
* paid roles in Victorian AOD services for lived/living experience peer workers.

The census supports the [*Mental health workforce strategy*](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy) <www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy> initiative to ‘further develop and expand the lived experience workforce’ and [*Victoria’s alcohol and other drugs workforce strategy 2018–2022*](https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022) <[www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022](https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022)> by providing benchmarking data about lived experience positions in Victoria.

This report provides information about lived experience positions to inform workforce development planning. The information collected in this survey allows changes to the lived experience workforce to be measured over time and supports the ability to connect people in similar positions, especially where there may be few across the state – for example, lived experience workers in management roles.

Organisations may find the information in this report useful for promoting, reviewing and planning lived experience positions within their service.

# Lived experience roles and functions in Victoria

Lived experience can be summarised as the expertise one gains through life experiences rather than from formal learning.

The lived experience workforce has emerged as the most rapidly expanding discipline in mental health services since the first positions were created in 1999. A full history of lived experience positions in mental health services can be found in the [*Lived experience workforce positions report 2017*](https://www2.health.vic.gov.au/mental-health/workforce-and-training/lived-experience-workforce) <https://www2.health.vic.gov.au/mental-health/workforce-and-training/lived-experience-workforce> and via the [[Centre for Mental Health Learning (CMHL) Peer Inside resource hub](https://cmhl.org.au/resource-hub?search_api_fulltext=history)](https://cmhl.org.au/resource-hub) <https://cmhl.org.au/resource-hub>.

In the context of mental health, lived experience relates to the experience of being a consumer/service user of mental health services, or as a family member/friend/carer who is supporting a person with mental health issues. Lived experience workers are employed on the basis of their experience, which is an essential criterion of their job.

In Victoria the AOD peer workforce is recognised as an integral part of AOD service delivery, leading to the integration of AOD peer workers across many organisations.

In the context of AOD, living or lived experience relates to the personal experience of AOD use and engagement in recovery and treatment services and/or harm reduction services. It may also relate to the living or lived experience of supporting a family member or friend in their recovery from addiction.

## Peer work, peer support and lived experience

There are inconsistencies in the use and understanding of the terms ‘peer support’, ‘peer work’, ‘peer support work’ and ‘lived experience’ work. Lived experience work emerged in its earliest form in the 1950s from grassroots mutual self-help organisations such as Alcoholics Anonymous and is underpinned by the peer support model of mutually offered and reciprocal social, emotional and/or practical support. A full history of peer work, peer support and lived experience can be found on the [CMHL resource hub](https://cmhl.org.au/resource-hub?search_api_fulltext=history) <https://cmhl.org.au/resource-hub?search\_api\_fulltext=history>.

## Describing different lived experience roles in mental health settings

### Peer support work

**Consumer peer support workers** use their personal lived experience of mental illness and recovery to support other consumers.

**Carer peer support workers** use their experience of supporting a family member or friend who has experienced mental illness to support family members and friends of consumers.

Peer support work focuses on building mutual and reciprocal relationships where understanding and emotional, social, spiritual and physical wellbeing and recovery are possible. Peer support workers may work with individuals or groups. This is highly skilled and specialised work that requires training and ongoing supervision from experienced peer support workers.

### Consultants

**Consumer consultants** collate information and feedback from consumers about their views and experiences of a service and use this information to make recommendations for service improvement.

**Carer consultants** collate information and feedback from families and carers about their views and experiences of a service.

The focus of consultant work is service improvement, with particular attention to practices, policies and procedures that affect access and equity. The work involves co-design, community engagement, networking, planning, evaluation, facilitation and communication skills.

### Managers

**Lived experience managers** are experienced consumer or family/carer workers who support and develop other lived experience workers. They may or may not line-manage staff or provide practice supervision for, or mentor, other workers.

### Educators

**Consumer and family/carer educators** ensure consumer and family/carer perspectives, participation and involvement are included in all aspects of education and training provided in services. Consumer and family/carer educators also facilitate or co-facilitate education and training for staff, consumers and carers.

### Advocates

**Consumer advocates** support consumers to have a voice and be a party to issues that affect them.

**Carer advocates** support family/carers to be heard in relation to issues that affect them.

Advocates support an individual or group to speak on their own behalf and in their own interests, or they may speak for and/or on behalf of an individual or group under instruction.

**Consumer policy advisors** draw on the considerable body of collective consumer knowledge and research (both published and in grey literature) to inform systemic change and bring about change to laws, policy, procedures and bureaucracy that cause or perpetuate injustice or inequity.

Similarly, **carer policy advisors** draw on the body of collective carer knowledge and research to inform changes to those aspects of the mental health system that affect families and carers and to promote family/carer sensitive practice.

### Research

**Consumer and carer researchers** draw on their lived experience to promote and enable the engagement of consumers and carers at all stages of research. Consumer and carer researchers may be involved as advisors in others’ research, as partners in collaborative research, or as leaders – initiating, directing and driving research.

## Describing different living and lived experience roles in AOD settings

### Peer workers

**AOD peer workers** that support people in treatment settings use their personal living and/or lived experience of AOD use, plus skills learned in formal training, to deliver services in support of others.

AOD peer work positions in harm reduction settings often benefit from being held by peers who are currently affected by overdose risk and connected with their immediate community. Harm reduction peer workers use their sound knowledge of overdose risks and responses, harm reduction strategies, plus skills learned in formal training, and seek to work with people where they are while balancing this with other risks such as criminalisation.

AOD peer workers may also use their living and lived experience to work from the perspective of supporting a family member or friend who is supporting someone in their recovery.

AOD peer workers are often employed in services under various titles such as peer educator, peer mentor or harm reduction peer worker. Sometimes the word ‘peer’ is removed altogether and replaced with something like ‘consultant’.

AOD peer workers provide non-clinical assistance, using their personal experiences in a way that promotes understanding and fosters connection. Peer workers offer support to others who have shared experiences by:

* facilitating authentic connections
* sharing their personal experiences in a way that inspires hope
* offering help and support as an equal within a defined role
* developing positive relationships that show the power and possibility of change.

### Managers

**Lived experience managers** are experienced AOD peer workers who support and develop other AOD peer workers. They may or may not line-manage staff or provide practice supervision for, or mentor, other workers.

# Policy context

## Mental health lived experience workforce strategies

The strategies for the consumer mental health workforce and for the family carer mental health workforce in Victoria were released on 1 July 2019. The intention behind each of these strategies is to support the resourcing and planning of lived experience workforce training and development over the coming years. Each of the strategies will assist policy developers, funders, lived experience workers and their employers, and will be useful to organisations planning to employ lived experience workers.

[Download the strategies](https://cmhl.org.au/peer-inside-our-work) <https://cmhl.org.au/peer-inside-our-work>.

## Mental health workforce strategy

Victoria’s mental health strategy was published on 28 July 2016 as a key deliverable of *Victoria’s 10-year mental health plan*. Further development and expansion of the lived experience workforce was identified as one of the key initiatives outlines in the strategy.

[[Download [the](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy)](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy) strategy](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy) <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/mental-health-workforce-strategy>.

## Fifth national mental health and suicide prevention plan

The *Fifth national mental health and suicide prevention plan* was released in August 2017 and comprises a nationally agreed set of priority areas and actions to build a stronger, more accountable, efficient and effective mental health system. The fifth plan identifies lived experience and peer-based interventions as a central part of effectively tackling stigma and discrimination.

[Download [the fifth plan](https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention)](https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention) <https://www.mentalhealthcommission.gov.au/Monitoring-and-Reporting/Fifth-Plan/5th-National-Mental-Health-and-Suicide-Prevention>.

## National Mental Health Commission peer workforce development guidelines

Under the *Fifth national mental health and suicide prevention plan*, the National Mental Health Commission is leading the development of peer workforce guidelines. In collaboration with RMIT University, the commission conducted a national online survey to help inform the initial draft of the guidelines.

Go online Further information and updates regarding the development of the [peer workforce development guidelines](https://www.mentalhealthcommission.gov.au/Mental-health-Reform/Mental-Health-Peer-Work-Development-and-Promotion/Peer-Workforce-Development-Guidelines) can be accessed here: <https://www.mentalhealthcommission.gov.au/Mental-health-Reform/Mental-Health-Peer-Work-Development-and-Promotion/Peer-Workforce-Development-Guidelines>.

## Royal Commission into Victoria’s Mental Health System

In February 2019, the Victorian Government announced a landmark Royal Commission into Victoria’s Mental Health System. In November 2019, the Royal Commission delivered its interim report, and in March 2021, its final report.

Both the interim report and the final report from the Royal Commission outline a vision for a system in which the lived experience workforces complement the mental health workforce of the future, are integral to multidisciplinary teams and care models, and shape the design and delivery of services. They envisage that lived experience work will span all aspects of the mental health and wellbeing system and associated services. This is a longer-term endeavour, and it calls for consideration of the skills and capabilities that will be needed to support the growth of lived experience workforces, particularly in areas involving new functions and roles.

New roles will be considered in the context of the entire system and the crucial areas of influence and change. As such, there is an immediate need to develop priorities for foundational actions that will support and enhance current lived experience workforces, along with establishing the pathways for growth in their size and reach. Understanding the size, composition, and distribution of the lived experience workforces in Victoria is an important first step in understanding how to proceed.

[[Download the royal commission’s final report](https://finalreport.rcvmhs.vic.gov.au/)](https://finalreport.rcvmhs.vic.gov.au/) <https://finalreport.rcvmhs.vic.gov.au/>.

## Productivity Commission Mental Health Inquiry Report

The final report of the inquiry was released on 16 November 2020, covering the key influences on people’s mental health, the implications of mental illness, and recommendations to State and Territory governments to improve the mental health of the Australian population. The inquiry recommended reforms that extend across all levels of society.

The report identifies the impact of the support offered by lived experience workers and notes that lived experience workers are highly valued by people in recovery from mental illness. The report identifies some of the gaps in knowledge about lived experience workers, and the challenges faced by lived experience workers. The report recommends that the peer workforce needs its own professional organisation to support training, development, role clarity, supervision, and support. [Tthe [report](https://www.pc.gov.au/inquiries/completed/mental-health/report)](https://www.pc.gov.au/inquiries/completed/mental-health/report) <https://www.pc.gov.au/inquiries/completed/mental-health/report>.

## Strategy for the alcohol and other drug peer workforce in Victoria

The strategy for the AOD peer workforce in Victoria was released on 1 July 2019. The strategy’s intention is to support the resourcing and planning of the training and development of the AOD peer workforce over the coming years. The strategy will assist policy developers, funders, AOD peer workers and their employers, and will be useful to organisations planning to employ AOD peer workers.

[Download the [strategy](https://www.sharc.org.au/sharc-programs/peer-projects/information-sheets-and-resources/)](https://www.sharc.org.au/sharc-programs/peer-projects/information-sheets-and-resources/) <https://www.sharc.org.au/sharc-programs/peer-projects/information-sheets-and-resources/>.

## Victoria’s alcohol and other drugs workforce strategy

*Victoria’s alcohol and other drugs workforce strategy 2018–2022* sets the direction for workforce development and planning for Victoria’s AOD treatment sector. The peer workforce is mentioned extensively throughout the strategy, with further development, expansion, integration and support of the peer workforce in organisations and services identified as key to delivering person-centred, integrated care. The strategy identified establishing a peer-led network designed to expand harm reduction activities as one of the key areas of reform in the sector.

[Download the [strategy](https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022)](https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022) <https://www2.health.vic.gov.au/about/publications/researchandreports/victoria-alcohol-other-drugs-workforce-strategy-2018-2022>.

# Current statewide funded programs

## Expanding post-discharge support

Since 2016 the department has funded the Expanding Post Discharge Support initiative. The initiative has seen an expansion of peer support roles, with almost all lived experience roles in clinical services being employed as part of the initiative. The initiative sought to reduce readmission rates to acute adult inpatient units within the first 28 days of discharge through peer support and increased connectedness.

In 2018 the department’s Centre for Evaluation and Research undertook a research project to explore the workplace experiences of lived experience workers employed by the initiative. The research sought to answer questions about the benefits of the lived experience workforce to consumers and carers, the challenges and enablers to integrating lived experience workforce into clinical mental health services and understanding the ways in which the integration of peer work force models can be improved and supported.

[Download the [findings from the research report](https://www2.health.vic.gov.au/about/publications/ResearchAndReports/expanding-post-discharge-support-initiative-report)](https://www2.health.vic.gov.au/about/publications/ResearchAndReports/expanding-post-discharge-support-initiative-report) <https://www2.health.vic.gov.au/about/publications/ResearchAndReports/expanding-post-discharge-support-initiative-report>.

## Consumer and carer consultants in area mental health services

Lived experience representation in the workforce is an enormously valuable component of the public mental health service system. This representation includes consumer and carer consultants and peer support workers. The department introduced the roles of consumer and carer consultants within services to ensure consumer, family and carer perspectives inform all aspects of service planning and delivery. The roles play a separate but equally important function to the individual peer support workforce, in that their focus is improvement at the health service and system levels.

Consultants may receive direct feedback from consumers and carers, represent consumers and carers at meetings, have input into policymaking and training, and promote consumer-focused, recovery-oriented, service delivery. They promote consumer and carer participation in all levels of decision making and are placed at the centre of policy and practice change as partners in co-design and co-production. Consultants are employed in each area mental health service across Victoria, having local influence and working together across services to ensure higher level mental health reform.

## Peer workers in prevention and recovery centres

Six ongoing peer worker positions were allocated to six nominated prevention and recovery centres (PARCs) from the 2018–19 financial year. The recruitment of these roles is guided by lessons from implementing peer support positions in acute mental health services. By having peer support in subacute settings consumers have the opportunity to benefit at a different stage of their recovery. Area mental health services involved are St Vincent’s, Melbourne Health, Eastern Health, Alfred Health, Mercy Health and Peninsula Health.

## Centre for Mental Health Learning

CMHL is the central agency that connects, collects and shares the information, tools, resources and expertise for public mental health, including lived experience, workforce learning and development in Victoria.

CMHL has a dedicated webpage for lived experience workforce called ‘Peer Inside’. This provides information about the lived experience workforce, including workforce development strategies, resources and training to increase organisational readiness for including lived experience workers. It also houses the lived experience workforce supervision database, which connects lived experience workers with suitable discipline-specific supervision for development and support.

[Visit the [Peer Inside webpage](https://cmhl.org.au/peer-inside-our-work)](https://cmhl.org.au/peer-inside-our-work) <https://cmhl.org.au/peer-inside-our-work> for more information.

There are two statewide positions that collaborate with mental health lived experience consumer and family carer workers as well as other key stakeholders to support the development of mental health consumer and family carer workforces in Victoria.

Email the Peer Inside team <peerinside@cmhl.org.au> for more information.

## Self Help Addiction Resource Centre

The Self Help Addiction Resource Centre (SHARC) promotes self-help approaches to recovery for those needing support for substance use or addiction.

Peer Projects supports the growth, development and sustainability of Victoria’s AOD peer workforce by providing services under the SHARC Peer Worker Model. Peer Projects places peer workers within Victorian AOD services and within the justice system. Services include SHARC peer worker training, peer worker practice supervision, organisational readiness training and the AOD peer workforce community of practice. Peer Projects provides a dedicated effort in AOD peer workforce development and operates as a sector resource for peer support initiatives.

[Visit the SHARC website for information and resources](https://www.sharc.org.au/sharc-programs/peer-projects/information-sheets-and-resources/) <https://www.sharc.org.au/sharc-programs/peer-projects/> or email the Peer Projects team <peersupport@sharc.org.au>.

## Reducing harmful drug use through utilising peer-led networks

In 2017 Harm Reduction Victoria and the Association of Participating Service Users were funded to provide support to the ‘Reducing harmful drug use through utilising peer-led networks’ project. This was one of a range of department-funded initiatives aimed at reducing opiate overdose and other harms related to illicit drug use. Six organisations developed projects in the first year with localised responses to issues in their geographic area. Using peer networkers and peer workers was encouraged to engage the affected community. The program also facilitates regular peer support meetings for people employed as harm reduction peer workers.

[Find more information on the [Harm Reduction Victoria website](https://www.hrvic.org.au/)](https://www.hrvic.org.au/) <https://www.hrvic.org.au/> or email the team <info@hrvic.org.au>.

# Scope of positions in this report

Several Victorian lived experience roles require consumer or family/carer perspectives. For example, there are department-funded consumer academic and carer academic positions attached to universities, and there are consumer and family/carer positions in government that provide policy and practice advice or lead project work (such as at the Mental Health Complaints Commission). VMIAC, the peak body for people with lived experience of mental health or emotional issues, is entirely staffed by consumers. Tandem, the peak body for mental health carers and family, has many staff with lived experience as a family member or carer. The CMHL, SHARC and Harm Reduction Victoria all have lived experience workforce development roles and often have project leads with lived experience for time-limited initiatives.

These roles are not reflected in this report, which is limited to lived experience positions in Victorian public mental health services. However, future iterations of the census or other reports that may be implemented will aim to build a picture of all dedicated lived experience roles that contribute to the mental health and AOD sectors.

# Data collection

This section provides information on data collected about lived experience workforce positions within Victorian public mental health services and AOD services. The data comes from area mental health services (clinical services), mental health community support services (non-clinical) and AOD treatment and harm reduction services. The data was collected in 2019–20 by the department’s Mental Health and AOD Workforce Team. This section also details some comparisons with data reported in 2017 where applicable.

The data collection tool used was a Microsoft Excel spreadsheet containing the survey questions, which comprised a combination of closed-ended dropdown questions and open-ended comment box questions.

## Questions

The survey asked mental health and AOD services to provide a contact for ongoing liaison for the lived experience workforce and asked for the following information about each dedicated lived experience position in the service:

* perspective (consumer or family/carer)
* position title
* type of service/organisation
* FTE
* age cohort the position supports
* location.

It also asked specific questions:

* Is the position employed in a particular program or initiative?
* Is the position currently filled or vacant?
* How long has the current incumbent been in the position?
* Does the person in this role manage staff?
* Does the person in this role provide lived experience supervision to other lived experience workers in the organisation?
* Does the person in this role receive discipline-specific supervision?

Note: Discipline-specific supervision or lived experience supervision is discipline-specific supervision to support practice development. It is the same as a nurse providing another nurse with practice supervision but is not the same as line management.

## Responses

Data was requested from 38 services. Thirty services responded by reporting on lived experience positions in the following settings:

* 22 area mental health services
* 15 other organisations, including mental health community support services, community health and AOD services.

## Limitations

The data presented in this report only reflects the positions reported by services that responded to the survey. It may not reflect all lived experience positions in Victoria’s mental health and AOD services. The survey was originally developed with mental health settings in mind, and it may not have been as effective at capturing comprehensive data in the AOD sector. These issues are being addressed through engagement and collaboration with the lived experience workforce in the AOD sector.

The data does not indicate an exact headcount of people occupying lived experience positions. It is unclear how many workers are occupying more than one of these positions. Data collected from a 2017 lived experience workforce training needs analysis indicates that approximately 40 per cent of lived experience workers work in more than one position.

Another limitation is that it is unclear how each position and title is defined at each service. Anecdotally, it is understood that there is inconsistency in role functions from service to service.

As previously mentioned in this report, the data is limited to public mental health and AOD services in Victoria and does not capture lived experience employees in peak bodies, government or other organisations, including those with lived experience who are not in designated lived experience roles.

# Lived experience workforce positions in mental health services

The census survey found the following:

* There are 457 reported positions within Victorian state-funded mental health services compared with 341 reported in 2017.
* The positions amount to 250 FTE positions.
* The average FTE is 0.63.
* 39 positions are employed casually, an increase from 7 per cent of the workforce in 2017 to 8.5 per cent in 2019.
* 50.3 per cent (*n* = 229) of the total workforce reported receiving discipline-specific supervision.
* 11.1 per cent *(* = 51) of the total workforce reported providing discipline-specific supervision to other lived experience workers in the organisation.
* There were 42 vacancies at the time of census reporting.

Compared with the 2017 results, there was a slight decrease in all categories except for positions employed casually. Most positions are employed at three days or fewer, with 64 per cent in 2019 and 59 per cent in 2017.

## Roles and perspectives

Less than one-third (*n =* 98) of the lived experience workforce in Victoria work from a family carer perspective, with more than two-thirds (*n =* 359) working from a consumer perspective. A significant proportion of both consumer and family/carer perspective workers are peer support workers (*n =* 321) and a lower proportion of family/carer workers (*n =* 61) are providing peer support when compared with the number of consumer peer support workers (*n =* 260). There is a relatively even number of both consumer and carer consultant roles across the state, with 36 consumer consultant and 27 carer consultant positions. Other roles included manager (*n =* 10), educator or trainer (*n =* 16), coordinator (*n =* 14) and researcher (*n =* 4). Twenty-eight positions were categorised as ‘Other’.

The proportion of workforce in all roles has been relatively stable from 2017 to 2019. Each role has a greater proportion of consumer workers than family/carer perspective workers. However, this proportion is substantially less among the consultant category. Peer support workers make up the majority of the overall workforce (2017: 62 per cent; 2019: 66 per cent), followed by consultants (2017: 22 per cent; 2019: 13 per cent).

The number of lived experience workers in each role type is shown in Table 1.

 Table 1: Roles and perspectives – family/carer and consumer perspectives

| Role | 2017 | 2019 |
| --- | --- | --- |
| Family/carer perspective | 102 | 98 |
| Consumer perspective | 239 | 359 |
| Peer support workers (overall) | 211 | 321 |
| Peer support workers (family/carer) | 52  | 61 |
| Peer support workers (consumer) | 159 | 260 |
| Manager (overall) | 6 | 10 |
| Manager (family/carer) | 2 | 3 |
| Manager (consumer) | 4 | 5 |
| Educator or trainer (overall) | 18 | 16 |
| Educator or trainer (family/carer) | 2  | – |
| Educator or trainer (consumer) | 16 | 8 |
| Coordinator (overall) | 7 | 15 |
| Coordinator (family/carer) | 1 | 3 |
| Coordinator (consumer) | 6  | 12 |
| Consultant (overall) | 74 | 63 |
| Consultant (family/carer) | 36 | 27 |
| Consultant (consumer) | 38 | 35 |

Across all role types, there were considerably more lived experience positions within clinical services (*n =* 267) compared with those in non-clinical settings (*n =* 184) in 2019.

An unexpected trend from the previous census is the decrease in the number of consultants (2017: 74; 2019: 63) and increase in coordinator roles (2017:7; 2019:15). There was also a small decrease in educator/trainer (2017:18; 2019: 16) and a substantial increase in peer support workers (2017: 211; 2019:321). This can be attributed to including an agency that was not counted in the 2017 data.

The number of lived experience workers in each type of role in clinical services and in non-clinical settings are listed in Table 2.

Table 2: Roles and perspectives – roles by clinical and non-clinical settings

| Role | 2017 | 2019 |
| --- | --- | --- |
| Peer support workers (overall) | 211 | 321 |
| Peer support workers (clinical services) | 134  | 141 |
| Peer support workers (non-clinical) | 77 | 180 |
| Manager (overall) | 6 | 10 |
| Manager (clinical services) | 5 | 5 |
| Manager (non-clinical) | 1 | 5 |
| Educator or trainer (overall) | 1 | 16 |
| Educator or trainer (clinical services) | 18  | 4 |
| Educator or trainer (non-clinical) | 12 | 12 |
| Coordinator (overall) | 6 | 15 |
| Coordinator (clinical services) | 6 | 5 |
| Coordinator (non-clinical) | 1  | 10 |
| Consultant (overall) | 74 | 63 |
| Consultant (clinical services) | 66 | 62 |
| Consultant (non-clinical) | 8 | 61 |

Figures 1 and 2 both compare the proportion of participants in different roles, first between 2017 and 2019, and then between clinical and non-clinical settings.

Figure 1: Comparison of lived experience roles from 2017 to 2019

Figure 2: Comparison of lived experience roles in 2019 between clinical and non-clinical settings

## Program initiative or affiliation

New information gathered in the 2019 census included whether positions were employed in a particular program or initiative and, if so, what the program or initiative was.

The programs and initiatives reported were the Expanding Post Discharge Support initiative (*n =* 82) and peer workers in PARCs (*n =* 8). A significant proportion reported an affiliation but did not know (*n =* 8) or did not specify (‘other’ = 253). A significant number of respondents reported not being employed in a particular program or initiative (*n =* 86).

The finding that a quarter of the workforce are employed with the Expanding Post-Discharge Support initiative is expected, given the increase in the workforce group noted above. Because this was a new question in the 2019 census, it is not clear how much impact the NDIS has had on this cohort.

Figure 3 shows the proportion of participants employed in a particular program (both stated and not stated) compared with those not employed in a particular program or initiative.

Figure 3: Proportion of the workforce employed in a particular program or initiative

# Mental health consumer workforce positions

In 2019, 78 per cent (*n =* 359) of the reported positions were occupied by people with a lived experience of mental illness, an increase from 239 in 2017. In 2019 the total FTE was 192 employed at an average of 0.67 FTE. In 2017 the total FTE was 190 working an average of 0.62 FTE, meaning that the total FTE and average FTE have remained stable over time despite the addition of 120 positions reported in the latest survey. There were 29 vacancies at the time of reporting compared with 19 in 2017.

Of the 359 mental health consumer positions reported, 48 per cent (*n =* 173) were employed within clinical mental health settings compared with 62 per cent (*n =* 149) in 2017. Positions employed within mental health community support service settings made up 49 per cent (*n =* 179) of the total consumer workforce positions compared with 37 per cent (*n =* 90) in 2017. The rise in reported positions employed in non-clinical services is attributable to adding an agency that was not included in the 2017 census.

The new agency inclusion accounts for all of the new numbers (*n =* 91), meaning that, overall, the numbers have remained stable over time. Of these other settings, just 1.9 per cent (*n =* 7) were in community health services. The response rates from Victorian Primary Health Networks were low, and it is expected that there are positions that have not been reported in this survey.

Figure 4 provides a breakdown of the settings where participants were located in 2019, comparing clinical settings with each of the other settings.

Figure 4: Proportion of mental health consumer positions according to setting type – clinical settings compared with other settings

## Full-time equivalent positions – consumer workforce

The 359 overall reported consumer workforce positions amounted to 197 FTE employed at an average of 0.62 FTE. This breaks down as:

* 19 positions employed at 0.1 - 0.2 FTE
* 42 positions employed at 0.3 - 0.4 FTE
* 120 positions employed at 0.5 - 0.6 FTE
* 79 positions employed at 0.7 - 0.8 FTE
* 52 positions employed at 0.9 FTE or full time positions
* 39 positions were employed as casual, and
* 8 positions did not specify their FTE

The survey did not capture anything about the terms of employment such as ongoing positions or fixed-term contracts.

Figure 5: Consumer workforce positions by FTE

## Consumer workforce positions by settings

While the graph in Figure 5 shows the number of lived experience positions within each clinical service, it does not compare positions or FTE positions with population or service size. NorthWestern Mental Health positions are located across six mental health services including Orygen Youth Health.

The number of lived experience positions at each clinical and non-clinical service are listed in Table 3 and Table 4 respectively.

Table 3: Number of consumer positions in clinical services

| Service | 2017 | 2019 |
| --- | --- | --- |
| Albury Wodonga Health | 3  | 3 |
| Alfred Health | 11  | 12  |
| Austin Health | 14 | 5 |
| Ballarat Health Services | 2 | 2 |
| Barwon Health | 6  | 10 |
| Bendigo Health Psychiatric Services | 4 | 4  |
| Eastern Health | 8  | 18  |
| Forensicare | 0 | 9 |
| Goulburn Valley Area Mental Health Service | 5  | 3 |
| Latrobe Regional Hospital | 7  | 7  |
| Mercy Health | 4 | 8  |
| Monash Health | 8 | 7  |
| Northern Mallee Mental Health Service – Mildura Base Hospital | 2 | 5  |
| NorthWest Mental Health (six services including Orygen) | 28  | 39  |
| Peninsula Health | 12 | 15 |
| South West Healthcare | 8  | 6  |
| St Vincent's Hospital Melbourne | 7  | 22  |

Table 4: Consumer workforce positions in non-clinical services

| Service | 2017 | 2019 |
| --- | --- | --- |
| Breakthru | 4 | – |
| EACH | 7 | 7 |
| Ermha | 4 | 4 |
| Mind | 46 | 57 |
| Neami National | 12 | 23 |
| Wellways | – | 89 |

## Distribution of consumer workforce positions by location

A significant portion of the consumer positions are based in metropolitan Melbourne (*n =* 281), and 87 positions are based in 12 regional locations. This has implications for access to networks, training and other supports such as discipline-specific supervision for workers in regions.

For example, in the Central Highlands area there are only five reported lived experience positions working across different position types (consultants, peer support workers), suggesting there is a limited pool of relevant peers/mentors for lived experience workers to draw from for support and practice development.

There are small regional services where there are only one or two lived experience workers. They may work from different perspectives, meaning they have no discipline-specific supports to draw on from within their organisation, unlike their metropolitan counterparts.

The number of positions in each region are listed in Table 5.

Table 5: Number of lived experience positions by region

| Service | 2019 |
| --- | --- |
| Wimmera South West | 17  |
| Barwon  | 29  |
| Central Highlands | 5  |
| Western Melbourne | 26 |
| Brimbank Melton | 18  |
| **South Western Victoria Region total** | **95** |
| Mallee | 4  |
| Loddon Campaspe | 5 |
| Hume Moreland | 21 |
| North Eastern Melbourne | 85 |
| **North Western Victoria Region total** | **115** |
| Ovens Murray | 6 |
| Goulburn | 11 |
| Outer Eastern Melbourne | 13 |
| Inner Eastern Melbourne | 34 |
| **North Eastern Victoria Region total** | **64** |
| Outer Gippsland | 17 |
| Inner Gippsland | 29 |
| Southern Melbourne | 5 |
| Bayside Peninsula | 26 |
| **South Eastern Victoria Region total** | **77** |
| **Various** | **10** |

## Age cohorts supported by consumer workforce positions

Information on which age cohorts are supported by the positions was not requested in previous surveys, so no comparisons can be drawn to previous years.

In 2019 most consumer positions supported adults – more than one-third of the workforce (*n =* 218). A much smaller group supported adolescents or youth (*n =* 18), while just 2 positions supported the older persons cohorts. A small group also supported all age groups (*n =* 32). Ninety-one respondents did not specify the age cohort their position supported. Figure 6 shows this breakdown.

The reason for the low proportion of the workforce supporting older persons cohorts is not clear and would be worth understanding to ensure this group is not missing out on appropriate care.

Figure 6: Age cohorts supported by lived experience workforces

## Length of service – consumer workforce positions

Another new question asked in the 2019 census was how long the incumbent had been in the position. However, there were a substantial number of unspecified responses in relation to length of service (*n =* 163), limiting the ability to identify themes from this data.

Of the responses that could form an analysis, it was not unexpected for the results to show that a little under a third of the workforce has been employed in their role for less than a year (*n =* 65), with a fifth employed for one to two years (*n =* 43) and similar for two to three years (*n =* 45). The majority of the workforce (78 per cent) have been in their position for under five years.

There were significantly fewer respondents employed in their position for between three and 10 years than those employed in their position for less than three years (*n =* 48), with an additional 10 respondents having been employed for more than 10 years. This cohort with more than three years’ history in their position is a group with considerable skills and experience for the lived experience workforce more broadly.

Figure 7 shows the number of consumer positions according to years of experience.

Figure 7: Years of experience in the position – consumer workforce positions

## Leadership and supervision – consumer workforce positions

### Line managers – consumer workforce positions

In 2017 just eight consumer workforce positions provided line management to other staff, which jumped to 14 in 2019. While this is a welcome increase, most lived experience workers are line-managed by someone who does not work from a lived experience perspective. Sustained effort in this area is needed to ensure line managers of lived experience staff understand role functions so they can provide adequate support to lived experience workers.

Figure 8 shows the proportion of participants who manage others.

### Discipline-specific supervision – consumer workforce positions

Discipline-specific supervision is supervision provided by another person from the same discipline as the person receiving it. For many disciplines this type of supervision is a requirement of professional bodies and in some cases an industrial requirement. For lived experience workforces, this approach is increasingly being recognised as the best way to support workers to develop their own practice. For more information refer to the [*Consumer perspective supervision framework*](https://cmhl.org.au/search?key=consumer+perspective+framework) <https://cmhl.org.au/search?key=consumer+perspective+framework>.

Of the 359 consumer workforce positions reported in 2019, 34 positions provided discipline-specific supervision to other lived experienced workers. In 2017, only 16 consumer lived experience workers provided supervision to other lived experience workers, which was highlighted as a significant gap. While the 2019 figure is not huge, it does represent a significant increase. Of note, six per cent (*n =* 6) of the 87 positions in regional locations provide discipline-specific supervision, in comparison with nine per cent (*n =* 28) of the 281 reportedly providing discipline-specific supervision in metropolitan Melbourne. This indicates there is not a metro/regional divide in supervision as a proportion of the workforce.

In 2019, 46 per cent (*n =* 164) of positions reported receiving discipline-specific supervision, while 20 per cent (*n =* 74) reported that they had not received discipline-specific supervision. Of concern is that 30 per cent (*n =* 105) of participants either did not know or did not specify if they receive discipline-specific supervision. While vacant positions may account for some of this result, it more likely indicates that participants do not have a clear understanding of what discipline-specific supervision is.

These figures highlight a significant gap in availability of discipline-specific supervisors to support Victoria’s 359 consumer workforce positions.

Figure 8 shows the proportion of participants who manage others alongside the proportion who provide and receive discipline-specific supervision.

Figure 8: Number of the consumer workforce managing others and those providing or receiving discipline-specific supervision

# Mental health family/carer workforce positions

In 2019, 21 per cent (*n =* 98) of the reported positions were occupied by family/carers, a decrease of four positions from the 2017 survey. In 2019 the total FTE was 56.9 employed at an average of 0.58 FTE compared with 0.56 FTE in 2017, meaning that the average FTE has remained stable over time. There were 13 vacancies at the time of reporting compared with 19 in 2017.

Of the 98 family/carer positions reported, 95 per cent (*n =* 94) were employed within clinical mental health settings compared with 87 per cent (*n =* 89) in 2017. Positions employed within non-clinical settings made up five per cent (*n =* 4) of the total family/carer workforce positions compared with 13 per cent (*n =* 13) in 2017.

The decrease in family/carer positions was an unexpected trend after observing a significant rise in the overall number of lived experience workforce positions in the latest survey. The decrease in the reported family/carer positions in non-clinical services is attributed to organisations transitioning from mental health–specific services to providing NDIS services.

Figure 9 provides a breakdown of settings where participants were located in 2019, comparing clinical settings with each of the other settings.

Figure 9: Proportion of mental health family/carer positions according to setting type – clinical settings compared with other settings

## Full-time equivalent positions – family/carer positions

The 98 overall reported family/carer positions amounted to a total of 56 FTE, with an average of 0.58 FTE:

* 20 positions were employed at 0.6 FTE
* 17 positions were employed at 0.4 FTE
* 15 positions were employed at 0.5 FTE
* 14 positions were employed at 0.8 FTE
* eight positions were employed at 0.2 FTE
* six positions were employed at 0.7 FTE
* three positions were employed at 0.3 FTE.

Eight per cent (*n =* 8) of the total family/carer positions were employed in full-time roles, and seven survey respondents did not specify.

The survey did not capture anything about the terms of employment (such as ongoing positions or fixed-term contracts). However, 64 per cent of the total family/carer workforce positions (*n =* 98) were employed at 0.6 FTE or less, suggesting a somewhat casualised workforce.

Figure 10 shows the number of family/carer workforce positions by FTE.

Figure 10: Family/carer positions by FTE

## Family/carer positions by settings

While this graph at Figure 10 shows the number of lived experience positions within each clinical service, it does not compare positions or FTE positions with population or service size. NorthWestern Mental Health positions are located across six mental health services including Orygen Youth Health.

The number of family/carer positions at each clinical and non-clinical services are listed in Table 6 and Table 7 respectively.

Table 6: Family/carer workforce positions in clinical services

| Service | 2017 | 2019 |
| --- | --- | --- |
| Albury Wodonga Health | 1  | 1 |
| Alfred Health | 8  | 9 |
| Austin Health | – | – |
| Ballarat Health Services | – | – |
| Barwon Health | 2  | 3 |
| Bendigo Health Psychiatric Services | 2 | 2 |
| Eastern Health | 10  | 15 |
| Forensicare | – | 7 |
| Goulburn Valley Area Mental Health Service | 1  | 2 |
| Latrobe Regional Hospital | 3  | 3 |
| Mercy Health | 3 | 5 |
| Monash Health | 8 | 6 |
| Northern Mallee Mental Health Service – Mildura Base Hospital | 1 | 1 |
| NorthWest Mental Health (six services including Orygen) | 25  | 27 |
| Peninsula Health | 7 | 8 |
| South West Healthcare | 1  | 1 |
| St Vincent's Hospital Melbourne | 4  | 4 |

Table 7: Family/carer workforce positions in non-clinical services

| Service | 2017 | 2019 |
| --- | --- | --- |
| Breakthru | 1 | – |
| Cohealth | 1 | – |
| EACH | 5 | – |
| Mentis Assist | – | 1 |
| Mind | 4 | – |
| Neami National | – | 1 |
| Wellways | – | 2 |

## Distribution of family/carer positions by location

Most of the reported family/carer positions were located in metropolitan Melbourne (*n =* 86), and a total of 12 positions were reported across six regional services. There are inherent challenges for a workforce of this size, with particular consideration of family/carer workers in regional areas where opportunities for support, mentoring and professional development would present as genuine challenges.

The number of family/carer workforce positions in each region are listed in Table 8.

Table 8: Number of family/carer workforce positions by region

| Service | 2019 |
| --- | --- |
| Wimmera South West | 1  |
| Barwon  | 2  |
| Central Highlands | –  |
| Western Melbourne | 16 |
| Brimbank Melton | 7  |
| **South Western Victoria Region total** | **26** |
| Mallee | 1  |
| Loddon Campaspe | 2 |
| Hume Moreland | 7 |
| North Eastern Melbourne | 10 |
| **North Western Victoria Region total** | **20** |
| Ovens Murray | 1 |
| Goulburn | 2 |
| Outer Eastern Melbourne | 3 |
| Inner Eastern Melbourne | 23 |
| **North Eastern Victoria Region total** | **29** |
| Outer Gippsland | – |
| Inner Gippsland | 3 |
| Southern Melbourne | 2 |
| Bayside Peninsula | 18 |
| **South Eastern Victoria Region total** | **23** |
| **Various** | **–** |

## Age cohorts supported by family/carer positions

Information on which age cohorts are supported by the positions was not requested in previous surveys, so no comparisons can be drawn to previous years.

In 2019 more than half of the family/carer positions supported adults (*n =* 61). The next highest group supported all age groups (*n =* 17), followed by adolescent and youth (*n =* 13) and then older people (*n =* 5). Two positions did not state the cohort supported.

Of note was that a higher proportion family/carer positions (*n =* 5) supported older people in comparison with consumer workforce positions that support older people (*n =* 2).

Figure 11 shows the proportion of participants working with different age cohorts.

Figure 11: Age cohorts supported by family/carer positions

## Length of service – family/carer positions

Another new question asked in the 2019 census was how long the incumbent had been in the position.

The results revealed that more than half of the family/carer positions had been occupied for less than three years (*n =* 59). There were 25 positions that reported being in the role for anywhere from five to 10 or more years, demonstrating that at least one-quarter of the workforce had considerable skills and experience. Eleven per cent of survey respondents (*n =* 11) did not specify how many years they had occupied their role.

Figure 12 shows the number of consumer positions according to years of experience.

Figure 12: Years of experience in the position – family/carer positions

## Leadership and supervision – family/carer positions

### Line managers – family/carer positions

In 2017 just three family/carer positions provided line management to other staff. In 2019 this number increased marginally to five, despite the reduction of overall reported family/carer positions. The implication of low rates of line managers is that most lived experience workers are managed by someone who does not work from a lived experience perspective. Sustained effort in this area is needed to ensure line managers of lived experience staff understand role functions so they can provide adequate support to lived experience workers.

### Discipline-specific supervision – family/carer positions

As outlined earlier in this document, discipline-specific supervision is supervision provided by another person from the same discipline as the person receiving it.

Of the 98 family/carer workforce positions reported in 2019, 17 positions provided discipline-specific supervision to other lived experienced workers compared with 10 in 2017. This represents a growth in the number of family/carer workers able to provide discipline-specific supervision to other lived experience workers in their organisation.

In 2019, 63 per cent (*n =* 62) of positions reported receiving discipline-specific supervision, a significant amount when measured against the proportion of consumer workforce positions that reported receiving discipline-specific supervision. A quarter of the positions (*n =* 25) reported that they had not received discipline-specific, and 11 positions either did not know or did not specify if they had received discipline-specific supervision.

These figures highlight the need for an increased capability across the sector to provide support to all 98 family/carer positions.

Figure 13 shows the proportion of participants who manage others alongside the proportion who provide and receive discipline-specific supervision.

Figure 13: Number of the family/carer workforce managing others and those providing or receiving discipline-specific supervision

# AOD peer worker positions

The scope of the 2019 survey was expanded to include AOD peer work positions across Victorian state-funded AOD treatment and harm reduction services. Because this was the first time AOD peer workers have been included in the survey, the survey responses have established baseline data for measuring changes to the AOD peer workforce over time.

The census survey found the following:

* There are 56 reported AOD peer worker positions across treatment and harm reduction settings in Victorian state funded services
* the positions amount to 36 equivalent full time (FTE) positions
* the average FTE is 0.69
* 57 per cent (*n =* 32) of the total AOD peer workforce reported receiving discipline-specific supervision
* 10 per cent (*n =* 6) of the total AOD peer workforce reported providing discipline supervision to other AOD peer workers in the organisation
* there was just one vacancy at the time of reporting.

To preserve the anonymity of the AOD peer workforce the breakdown of data is presented at a much higher level, however there are still observable trends from the numbers presented.

## Roles and perspectives

The majority of positions (*n =* 52) are occupied by people who have living or lived experience of addiction, whilst only seven per cent of peer workers (*n =* 4) worked from the perspective of supporting a family member or friend who was supporting someone in recovery. Peer support worker was the most common role, making up 68 per cent of the total positions (*n =* 47).

A number of peer support worker roles were reported in the survey under differing titles such as peer educator, peer mentor, or consultant. It is understood that in instances the word ‘peer’ has been removed from job titles due to concerns that the title ‘peer’ could lead to stigma and discrimination directed towards peer workers by other colleagues. There are also instances of organisational policies whereby staff who have living or lived experience are not permitted to disclose their peer status. Coordinators were the next highest number of positions represented in the survey (*n =* 4), followed my manager (*n =* 4). One position was categorised as ‘other’.

The number of AOD peer workers in each type of role and setting can be seen in Table 9.

Table 9: Roles and perspectives – AOD treatment settings and harm reduction settings

| Role | 2019 |
| --- | --- |
| Treatment services | 40 |
| Harm reduction | 16 |
| Peer support workers (overall) | 47 |
| Peer support workers (treatment services) | 37 |
| Peer support workers (harm reduction) | 10 |
| Manager (overall) | 4 |
| Manager (treatment services) | 1 |
| Manager (harm reduction) | 3 |
| Coordinator (overall) | 4 |
| Coordinator (treatment services) | 2 |
| Coordinator (harm reduction) | 2 |

## Program initiative or affiliation

Almost all survey respondents either did not know or did not specify an affiliated program or initiative by which their positions are funded. It is known that the Reducing harmful drug-use through utilising peer--led networks’ program funds a number of positions. This provides a gap for further exploration in future iterations of this report.

## Distribution of AOD peer workers by service

The number of positions within each service are listed in Table 10. It does not compare positions or FTE positions with population or service size.

Table 10: Number of positions by service

| Service | 2019 |
| --- | --- |
| Ballarat Health Services | 2 |
| Banyule Community Health | 5  |
| Barwon Health | 2  |
| EACH | 4  |
| Goulburn Valley Health | 9 |
| Harm Reduction Victoria | 16  |
| Mercy Health | 1  |
| Monash Health | 2  |
| South West Healthcare | 2 |
| TaskForce community agency | 1 |
| Uniting ReGen | 1 |
| Windana | 10 |
| Youth Protects Inc. | 1 |

## Distribution of AOD peer workers by location

Most AOD peer workers are based in metropolitan Melbourne (*n =* 46), however, 18 of these positions are part of a statewide service. There are 12 positions based in regional areas. The low proportion of AOD peer workers in regional areas has implications for access to networks, training and other supports such as discipline-specific supervision.

The number of AOD peer work positions by region is listed in Table 11.

Table 11: Number of peer workers by region

| Service | 2019 |
| --- | --- |
| Wimmera South West | 1  |
| Barwon  | 2  |
| Central Highlands | 5  |
| Western Melbourne | 2 |
| Brimbank Melton | –  |
| **South Western Victoria Region total** | **10** |
| Mallee | –  |
| Loddon Campaspe | – |
| Hume Moreland | – |
| North Eastern Melbourne | 8 |
| **North Western Victoria Region total** | **8** |
| Ovens Murray | – |
| Goulburn | 9 |
| Outer Eastern Melbourne | 1 |
| Inner Eastern Melbourne | 2 |
| **North Eastern Victoria Region total** | **12** |
| Outer Gippsland | – |
| Inner Gippsland | – |
| Southern Melbourne | 8 |
| Bayside Peninsula | – |
| **South Eastern Victoria Region total** | **8** |
| **Various** | **18** |

## Age cohorts supported by AOD peer workers

More than half of the reported AOD peer worker roles supported adults (*n =* 31). The next highest cohort supported was all ages (*n =* 19). Five respondents did not specify the cohort they supported, and just one position supported adolescents and youth.

Figure 14 shows the proportion of participants working with different age cohorts.

Figure 14: Age cohorts supported AOD peer workers

## Full-time equivalent AOD peer worker positions in treatment settings

The 40 overall reported positions in AOD treatment settings amounted to 25 FTE, with an average of 0.69 FTE. Forty-five per cent (*n =* 18) of the positions were employed at 0.6 or 0.7 FTE. Two positions reported being employed at 0.9 FTE, and seven positions reported being employed full-time. The remaining five positions were employed between 0.2 and 0.4 FTE.

The survey did not capture anything about the terms of employment (such as ongoing positions or fixed-term contracts).

Figure 15 shows the number of AOD peer worker positions in treatment settings by FTE.

Figure 15: AOD peer worker positions in treatment settings by FTE

## Length of service – AOD peer worker positions in treatment settings

The survey responses indicated that 50 per cent of all reported AOD peer workers in treatment settings (*n =* 20) had been in their current role for less than a year. Twenty-five per cent of the positions (*n =* 10) reported that they had been in their current role for one to two years. There were significantly fewer respondents who had been in their role for more than two years, with the remaining seven positions reporting that their length of service was anywhere from two to 10 or more years. There were three respondents who did not specify their length of service.

Figure 16 shows the number of AOD peer worker positions in treatment settings according to years of experience.

Figure 16: Years of experience in the position – AOD peer worker positions in treatment settings

## Leadership and supervision – AOD peer worker positions in treatment settings

### Line managers – treatment settings

Of the 40 reported positions in AOD treatment settings, there were just two positions that provided line management to other staff. Such low numbers suggest that further understanding about career progression in the AOD peer workforce is required. Addressing this is an important part of organisational readiness.

Figure 17 shows the proportion of participants who manage others in treatment settings.

### Discipline-specific supervision – treatment settings

Forty per cent (*n =* 40) of the AOD peer worker positions in treatment settings reported receiving discipline-specific supervision. Thirty-two per cent (*n =* 13) of the reported positions did not receive discipline-specific supervision, and 27 per cent (*n =* 11) either did not know or did not specify if they had received discipline-specific supervision.

These figures indicate that not all of Victoria’s AOD peer workforce in treatment settings are able to access discipline-specific supervision, which may be due to lack of organisational awareness of the importance of this support structure.

Figure 17 shows the proportion of participants who manage others alongside the proportion who provide and receive discipline-specific supervision.

Figure 17: Number of AOD peer work positions in treatment settings managing others and those providing or receiving discipline-specific supervision

## Full-time equivalent AOD peer worker positions in harm reduction settings

The 16 overall reported positions in AOD treatment settings amounted to 9 FTE, with an average of 0.62 FTE. Fifty-six per cent (*n =* 9) of the positions were employed at 0.6 FTE or less. Two positions reported being employed at 0.9 FTE, and four positions reported being employed full-time.

The survey did not capture details about the terms of employment (such as ongoing positions or fixed-term contracts).

Figure 18 shows the number of AOD peer worker positions in harm reduction settings by FTE.

Figure 18: AOD peer worker positions in harm reduction settings by FTE

## Length of service – AOD peer worker positions in harm reduction settings

Of the total reported AOD peer work positions in harm reduction settings, there were six positions that had been in their role for less than a year, five positions with one to two years in their current role, two positions with three to five years in their current role, and two positions that had been in their current role for five to eight years. One survey respondent did not specify their length of service. These numbers mean that 68 per cent of the total harm reduction workforce’s length of service ranged from less than one year to two years. It must be acknowledged, however, that the sample size is only 16 positions overall.

Figure 19 shows the number of AOD peer worker positions in harm reduction settings according to years of experience.

Figure 19: Years of experience in the position – AOD peer worker positions in harm reduction settings

## Leadership and supervision – AOD peer worker positions in harm reduction settings

### Line managers – harm reduction settings

Of the 16 reported positions in AOD harm reduction settings, four positions provided line management to other staff. This figure represents one-quarter of the reported positions in harm reduction settings.

Figure 20 shows the proportion of participants who manage others in harm reduction settings.

### Discipline-specific supervision – harm reduction settings

Discipline-specific supervision supports peer workers with to develop their own practice. For many disciplines (for example, psychology and nursing), this type of supervision is mandatory because it is essential to further development and support for workers.

Ninety-three per cent (*n =* 15) of the AOD peer worker positions in harm reduction settings reported receiving discipline-specific supervision. This figure represented the highest rates of supervision received among any of the living or lived experience positions presented in this report. Just one survey respondent reported not receiving discipline-specific supervision.

Figure 20 shows the proportion of participants who manage others alongside the proportion who provide and receive discipline-specific supervision.

Figure 20: Percentage of the AOD peer workers in harm reduction settings managing others and those providing or receiving discipline-specific supervision

# Future focus

Although the data in this report begins to build a picture of lived experience positions in Victorian public mental health services, there is more to understand about functions of the roles, how these are supported, and what needs to be in place at the local level.

Consultation with the Lived Experience Workforce Advisory Group about the content of this report highlighted a number of gaps where the department can focus on deepening the understanding of the roles and how they are implemented at each service in partnership with the CMHL, Mental Health Reform Victoria, health services and the lived experience workforce.

The department will continue to monitor positions over time, with data collection planned at 18-month intervals. Future survey questions need to be tailored to both the mental health lived experience workforce and AOD peer workers, and to more specific data about worker diversity and the cohorts supported – for example, Aboriginal and Torres Strait Islander and LGBTIQ+ lived experience.

To support career pathways, it is important to understand the journey of people in lived experience leadership positions and the supports, training and structures required to support career development.

The rapid expansion of lived experience positions has created a need to provide greater clarity of different roles and perspectives across the mental health lived experience workforce and AOD peer workforce.

# Agencies consulted

Information was provided by the following services:

* Albury Wodonga Health
* Alfred Health
* Austin Health
* Ballarat Health Services
* Banyule Community Health Service
* Barwon Health
* Bendigo Health Psychiatric Services
* Carrington Health
* EACH
* Eastern Health
* ermha365
* Forensicare
* Goulburn Valley Health
* Harm Reduction Victoria
* Latrobe Regional Hospital
* Mentis Assist
* Mercy Health
* Mind
* Monash Health
* Neami National
* Northern Mallee Mental Health Service – Mildura Base Hospital
* NorthWestern Mental Health (six services including Orygen Youth Health)
* Peninsula Health
* Self Help Addiction Resource Centre (SHARC)
* South West Healthcare
* St Vincent’s Hospital Melbourne
* TaskForce Community Agency
* Uniting ReGen
* Wellways
* Windana Drug & Alcohol Recovery
* Youth Projects Inc.

# Helpful resources

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